

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0037937</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Ridgeland Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>12550 South Ridgeland Avenue</u> <u>Palos Heights</u> <u>60463</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(708) 597-9300</u> Fax # <u>(708) 597-2472</u>		(Type or Print Name) <u>Glenn Adrian</u>	
IDPA ID Number: <u>22-3152450001</u>		(Title) <u>Regional President</u>	
Date of Initial License for Current Owners: <u>05/01/92</u>		(Signed) _____ (Date) _____	
Type of Ownership:		Paid Preparer (Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Laura Hillenbrand</u> Telephone Number: <u>(304) 599-0395</u>			

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Ridgeland Center# 0037937 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>32</u>	Skilled (SNF)	<u>101</u>	<u>18,028</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>69</u>	Intermediate (ICF)		<u>18,837</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>101</u>	TOTALS	<u>101</u>	<u>36,865</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,284</u>	<u>2,864</u>	<u>5,232</u>	<u>14,380</u>	8
9	SNF/PED					9
10	ICF	<u>9,269</u>	<u>7,910</u>	<u>121</u>	<u>17,300</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,553</u>	<u>10,774</u>	<u>5,353</u>	<u>31,680</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 85.94%

D. How many bed-hold days during this year were paid by Public Aid?

35 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 05/01/92

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 05/01/92 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 101 and days of care provided 5,146Medicare Intermediary Riverbend Government Benefits Administrator

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number **Ridgeland Center**# **0037937**Report Period Beginning: **01/01/01**Ending: **12/31/01****V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	227,909	21,197	62,560	311,666		311,666	(3,702)	307,964			1
2	Food Purchase		152,698		152,698		152,698	(1,826)	150,872			2
3	Housekeeping	123,520	16,787	5,667	145,974		145,974	(334)	145,640			3
4	Laundry	12,833	12,194	36,538	61,565		61,565	(2,152)	59,413			4
5	Heat and Other Utilities			95,548	95,548		95,548		95,548			5
6	Maintenance	63,079	11,535	27,576	102,190		102,190		102,190			6
7	Other (specify):* Trash Removal			13,463	13,463		13,463		13,463			7
8	TOTAL General Services	427,341	214,411	241,352	883,104		883,104	(8,014)	875,090			8
	B. Health Care and Programs											
9	Medical Director			9,537	9,537		9,537		9,537			9
10	Nursing and Medical Records	1,516,278	154,584	473,048	2,143,910	3,592	2,147,502	(31,205)	2,116,297			10
10a	Therapy		62	356,041	356,103	554	356,657	(11,033)	345,624			10a
11	Activities	81,927	260	1,835	84,022		84,022	(48)	83,974			11
12	Social Services	85,186	129	2,626	87,941		87,941		87,941			12
13	Nurse Aide Training	3,237		350	3,587	(3,587)						13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,686,628	155,035	843,437	2,685,100	559	2,685,659	(42,286)	2,643,373			16
	C. General Administration											
17	Administrative	230,119	186	233,223	463,528	350	463,878	283,705	747,583			17
18	Directors Fees											18
19	Professional Services			18,072	18,072		18,072		18,072			19
20	Dues, Fees, Subscriptions & Promotions			8,548	8,548	(348)	8,200	(343)	7,857			20
21	Clerical & General Office Expenses		25,745	57,780	83,525	(399)	83,126	100	83,226			21
22	Employee Benefits & Payroll Taxes			473,937	473,937	290	474,227	70	474,297			22
23	Inservice Training & Education			844	844	(844)						23
24	Travel and Seminar			4,948	4,948		4,948		4,948			24
25	Other Admin. Staff Transportation			10	10		10		10			25
26	Insurance-Prop.Liab.Malpractice			37,269	37,269		37,269		37,269			26
27	Other (specify):* Misc Expense			1,727,855	1,727,855	392	1,728,247	(1,728,302)	(55)			27
28	TOTAL General Administration	230,119	25,931	2,562,486	2,818,536	(559)	2,817,977	(1,444,770)	1,373,207			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,344,088	395,377	3,647,275	6,386,740		6,386,740	(1,495,070)	4,891,670			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Ridgeland Center

#0037937

Report Period Beginning:

01/01/01

Ending:

12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			171,981	171,981		171,981	(12,364)	159,617			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							234,629	234,629			32
33	Real Estate Taxes			132,962	132,962		132,962		132,962			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			36,207	36,207		36,207	(1)	36,206			35
36	Other (specify):*											36
37	TOTAL Ownership			341,150	341,150		341,150	222,264	563,414			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			7,792	7,792		7,792		7,792			38
39	Ancillary Service Centers			234,671	234,671		234,671	(4,715)	229,956			39
40	Barber and Beauty Shops			19,247	19,247		19,247		19,247			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,722	52,722		52,722		52,722			42
43	Other (specify):*			4,641,637	4,641,637		4,641,637	(4,569,299)	72,338			43
44	TOTAL Special Cost Centers			4,956,069	4,956,069		4,956,069	(4,574,014)	382,055			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,344,088	395,377	8,944,494	11,683,959		11,683,959	(5,846,820)	5,837,139			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Ridgeland Center

0037937

Report Period Beginning: 01/01/01

Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,312)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(43,031)	30		9
10	Interest and Other Investment Income	(56)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(514)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,724,049)	27		24
25	Fund Raising, Advertising and Promotional	(6,615)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,775,577)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	526,413		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 526,413		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,249,164)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Ridgeland Center

ID# 0037937

Report Period Beginning: 01/01/01

Ending: 12/31/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	PAC Dues	\$ (343)	20	1
2	Non-recurring charges	(4,569,299)	43	2
3	Add on reversal of prior period costs	1,642	10	3
4	Add on reversal of prior period costs	70	22	4
5	Add on reversal of prior period costs	2,362	27	5
6	Remove contract labor over accrual	(32,088)	10	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,597,656)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ridgeland Center# 0037937

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(3,702)	0	0	0	0	0	0	0	0	0	(3,702)	1
2	Food Purchase	(1,826)	0	0	0	0	0	0	0	0	0	0	(1,826)	2
3	Housekeeping	0	(334)	0	0	0	0	0	0	0	0	0	(334)	3
4	Laundry	0	(2,152)	0	0	0	0	0	0	0	0	0	(2,152)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,826)	(6,188)	0	0	0	0	0	0	0	0	0	(8,014)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(30,446)	(759)	0	0	0	0	0	0	0	0	0	(31,205)	10
10a	Therapy	0	(11,033)	0	0	0	0	0	0	0	0	0	(11,033)	10a
11	Activities	0	(48)	0	0	0	0	0	0	0	0	0	(48)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(30,446)	(11,840)	0	0	0	0	0	0	0	0	0	(42,286)	16
	C. General Administration													
17	Administrative	0	283,705	0	0	0	0	0	0	0	0	0	283,705	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(343)	0	0	0	0	0	0	0	0	0	0	(343)	20
21	Clerical & General Office Expenses	0	100	0	0	0	0	0	0	0	0	0	100	21
22	Employee Benefits & Payroll Taxes	70	0	0	0	0	0	0	0	0	0	0	70	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,728,302)	0	0	0	0	0	0	0	0	0	0	(1,728,302)	27
28	TOTAL General Administration	(1,728,575)	283,805	0	0	0	0	0	0	0	0	0	(1,444,770)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,760,847)	265,777	0	0	0	0	0	0	0	0	0	(1,495,070)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ridgeland Center# 0037937

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(43,031)	30,667	0	0	0	0	0	0	0	0	0	(12,364)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(56)	234,685	0	0	0	0	0	0	0	0	0	234,629	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	(1)	0	0	0	0	0	0	0	0	0	(1)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(43,087)	265,351	0	0	0	0	0	0	0	0	0	222,264	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(4,715)	0	0	0	0	0	0	0	0	0	(4,715)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(4,569,299)	0	0	0	0	0	0	0	0	0	0	(4,569,299)	43
44	TOTAL Special Cost Centers	(4,569,299)	(4,715)	0	0	0	0	0	0	0	0	0	(4,574,014)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(6,373,233)	526,413	0	0	0	0	0	0	0	0	0	(5,846,820)	45

Facility Name & ID Number Ridgeland Center# 0037937

Report Period Beginning:

01/01/01

Ending:

12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Genesis Health Ventures	100	See Attached List		RLNR, INC.	Hackensack, NJ	Property Owner
				Neighborcare	Willowbrook, IL	Pharmacy
				Genesis Rehab	Kennett Square, PA	Therapy
				Genesis Hospitality	Kennett Square, PA	Dietary

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 Qtrly & Annual Reports	\$	RLNR, INC.		\$ 100	\$ 100	1
2	V	30 Depreciation		RLNR, INC.		30,667	30,667	2
3	V	32 Interest		RLNR, INC.		234,685	234,685	3
4	V	17 Administrative	233,223	Genesis Health Ventures	100.00%	516,928	283,705	4
5	V	1 Related party mark-up	34	Neighborcare			(34)	5
6	V	10 Related party mark-up	759	Neighborcare			(759)	6
7	V	35 Related party mark-up	1	Neighborcare			(1)	7
8	V	39 Related party mark-up	4,715	Neighborcare			(4,715)	8
9	V	11 Related party mark-up	48	Genesis Rehab			(48)	9
10	V	10a Related party mark-up	11,033	Genesis Rehab			(11,033)	10
11	V	1 Related party mark-up	3,668	Genesis Hospitality			(3,668)	11
12	V	3 Related party mark-up	334	Genesis Hospitality			(334)	12
13	V	4 Related party mark-up	2,152	Genesis Hospitality			(2,152)	13
14	Total		\$ 255,967			\$ 782,380	\$ * 526,413	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	Facility is owned by a public company								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Genesis Health Ventures, Inc.
 Street Address 101 E. State Street
 City / State / Zip Code Kennett Square, PA 19348
 Phone Number (610) 925-4079
 Fax Number (610) 925-4853

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	405	\$ 185,300,553	\$		\$ 516,928	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 185,300,553	\$		\$ 516,928	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	Mellon Bank Revolving Credit		X				\$ 3,136,703	\$ 3,136,703		10.0450	\$ 177,391	1							
2	Mellon Bank Revolving Credit		X				1,013,090	1,013,090		10.0450	57,294	2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 4,149,793	\$ 4,149,793			\$ 234,685	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 4,149,793	\$ 4,149,793			\$ 234,685	15							

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **Ridgeland Center**# **0037937** Report Period Beginning: **01/01/01** Ending: **12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.			\$	50,198	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	131,836	2
3. Under or (over) accrual (line 2 minus line 1).			\$	81,638	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	51,404	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	133,042	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1996	107,821	8		
	1997	109,538	9		
	1998	109,538	10		
	1999	132,539	11		
	2000	136,078	12		
				FOR OHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
Second half real estate tax payment recorded on the Property Holder in Prepaids. This payment has been included in line 2 and removed from line 4.				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ridgeland Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037937

CONTACT PERSON REGARDING THIS REPORT Laura Hillenbrand

TELEPHONE (304) 599-0395 FAX #: (304) 285-0624

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>24-30-404-033-0000</u>	<u>Long Term Care</u>	\$ <u>136,078.39</u>	\$ <u>136,078.39</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>136,078.39</u>	\$ <u>136,078.39</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:

24,446

B. General Construction Type:

Exterior

Frame

Number of Stories

1

C. Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	139,860	1992	\$ 25,000	1
2					2
3	TOTALS	139,860		\$ 25,000	3

Facility Name & ID Number Ridgeland Center# 0037937

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1992	1985	\$ 920,000	\$ 30,667	30	\$ 28,111	\$ (2,556)	\$ 293,889	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements		1993		14,495	796	20	725	(71)	5,739	9
10	Leasehold Improvements		1994		8,686	476	20	434	(42)	6,768	10
11	Leasehold Improvements		1995		28	1	20	1		8	11
12	Remodeling (earthwork, paving, carpentry, plumbing)		1996		17,375	955	20	869	(86)	5,001	12
13	Remodeling (earthwork, paving, carpentry, plumbing)		1996		7,906	435	20	395	(40)	2,304	13
14	Zoning fee		1996		120	7	20	6	(1)	37	14
15	Wallpaper		1996		3,117	172	20	156	(16)	858	15
16	Parking lot repaving		1996		4,500	247	20	225	(22)	1,239	16
17	Engineering fee		1996		605	33	20	30	(3)	167	17
18	Engineering fee		1996		325	18	20	16	(2)	79	18
19	Engineering fee		1996		1,439	77	20	72	(5)	396	19
20	Engineering fee		1996		1,100	59	20	55	(4)	301	20
21	Engineering fee		1996		330	19	20	17	(2)	96	21
22	Engineering fee		1996		1,711	95	20	86	(9)	476	22
23	Windows		1996		1,500	83	20	75	(8)	412	23
24	Cable		1996		766	39	20	38	(1)	212	24
25	Engineering for new water service test		1996		1,763	94	20	87	(7)	464	25
26	Ceiling work		1996		7,048	389	20	353	(36)	1,880	26
27	Engineering for new water service test		1996		1,364	73	20	68	(5)	364	27
28	Blueprinting		1996		59	3	20	3		14	28
29	Engineering for new water service test		1996		1,128	62	20	56	(6)	290	29
30	Engineering for new water service test		1996		559	32	20	28	(4)	144	30
31	Legal consultation		1996		1,035	57	20	52	(5)	261	31
32	Electrical work		1996		909	51	20	46	(5)	239	32
33	VVE Security & communications wiring		1997		1,143	63	20	57	(6)	286	33
34	VVE Security & communications wiring		1997		48	2	20	2		13	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Ridgeland Center

0037937

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Security	1997	\$ 718	\$ 42	20	\$ 36	\$ (6)	\$ 180		37
38	Midwest food equipment	1997	4,918	268	20	245	(23)	1,183		38
39	Painting	1997	3,335	183	20	167	(16)	780		39
40	Painting	1997	1,885	106	20	94	(12)	439		40
41	Capitalized interest	1997	59,558	3,269	20	2,977	(292)	13,645		41
42	Capitalized interest	1997	928	51	20	46	(5)	208		42
43	CIP	1997	4,148	229	20	207	(22)	948		43
44	CIP	1997	484	26	20	24	(2)	110		44
45	Fire alarm & sheet metal	1997	1,277	70	20	64	(6)	292		45
46	Fire alarm	1997	1,368	74	20	68	(6)	313		46
47	Sheet metal	1997	266	14	20	13	(1)	59		47
48	Landscaping	1997	11,538	631	20	576	(55)	2,592		48
49	Air conditioning	1997	858	49	20	43	(6)	195		49
50	Air conditioning	1997	1,292	71	20	65	(6)	290		50
51	Water heater	1997	907	51	20	45	(6)	203		51
52	Heating/cooling	1997	306	15	20	15		70		52
53	Electric	1997	444	22	20	22		100		53
54	Hardware	1997	11	1	20	1		4		54
55	Install cubicle track	1997	1,165	64	20	58	(6)	262		55
56	Fire protection	1997	325	16	20	16		71		56
57	Fire protection	1997	1,172	65	20	59	(6)	266		57
58	Heating/cooling	1997	480	27	20	24	(3)	106		58
59	Heating/cooling	1997	1,376	75	20	69	(6)	302		59
60	Electric	1997	1,488	80	20	74	(6)	326		60
61	Water heater	1997	907	51	20	45	(6)	196		61
62	Install cubicle track	1997	1,165	64	20	58	(6)	257		62
63	Electric	1997	11,514	630	20	575	(55)	2,540		63
64	Electric	1997	480	24	20	24		106		64
65	Construction fees for addition 14 bed unit	1997	2,891,042	82,601	35	82,601		337,287		65
66	Therapy gym renovation of air conditioning									66
67										67
68	Replace nurses station counter top	1998	1,440	34	35	34		136		68
69	Metal letters for bldg front sign	1998	2,090	45	35	45		180		69
70	TOTAL (lines 4 thru 69)		\$ 4,007,944	\$ 123,953		\$ 120,453	\$ (3,500)	\$ 685,583		70

**Improvement type must be detailed in order for the cost report to be considered complete.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,007,944	\$ 123,953		\$ 120,453	\$ (3,500)	\$ 685,583	1
2	Install new windows in the bldg	1998	30,808	660	35	660		2,640	2
3	Shelf liners & closet hardware	1998	146	3	35	3		12	3
4	Replace toilet seat	1998	102	3	35	3		12	4
5	Shelf liners & closet hardware	1998	1,119	22	35	22		88	5
6	Replace facility roof	1998	25,000	429	35	429		1,716	6
7	Replace facility gutters & downspouts	1998	4,972	85	35	85		340	7
8	Replace facility roof	1998	33,236	499	35	499		1,996	8
9	Replace heating & a/c handling units	1998	22,570	290	35	290		1,160	9
10	Chatain & Co	1998	1,148	13	35	13		52	10
11	Install smoke barrier	1998	4,830	41	35	41		164	11
12	Electrical work for replacing heating & a/c	1998	1,599	13	35	13		52	12
13	Replace heating & a/c handling units	1998	3,950	34	35	34		136	13
14	Painting service	1998	10,800	209	35	209		836	14
15	Flooring	2000	799	23	35	23		46	15
16	Install Fire sprinkler svstem	2000	71,848	2,053	35	2,053		4,106	16
17	Punch key locks	2000	1,190	34	35	34		68	17
18	Sprinkler svstem	2001	23,100	660	35	660		660	18
19	Wheelchair ramp	2001	2,700	77	35	77		77	19
20	Sidewalk	2001	4,003	200	20	200		200	20
21	Sprinkler system	2000	59,520	2,976	20	2,976		5,952	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,311,384	\$ 132,277		\$ 128,777	\$ (3,500)	\$ 705,896	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 225,898	\$ 61,249	\$ 30,937	\$ (30,312)	7	\$ 137,731	71
72	Current Year Purchases	18,722	2,879	2,879		3-7 yrs	2,879	72
73	Fully Depreciated Assets	642,299					642,299	73
74								74
75	TOTALS	\$ 886,919	\$ 64,128	\$ 33,816	\$ (30,312)		\$ 782,909	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,223,303	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 196,405	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 162,593	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (33,812)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,488,805	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 31,708 Description: Admin \$3168, Act \$56, Diet \$1120, Hskpng \$42, Maint \$388, Nursing \$26934

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Use	1999 Plymouth Voyager	\$ 409.00	\$ 4,499	17
18					18
19					19
20					20
21	TOTAL		\$ 409.00	\$ 4,499	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 2 & 3	hrs	\$	3,918	\$ 187,274	\$ 62	3,918	\$ 187,336	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		206	9,443		206	9,443	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		3,157	159,324		3,157	159,324	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescrpts				230,781		230,781	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	7,281	\$ 356,041	\$ 230,843	7,281	\$ 586,884	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 196,032	\$ 196,032	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,278,298	1,278,298	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	(649)	64,919	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,473,681	\$ 1,539,249	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,003	29,003	13
14	Buildings, at Historical Cost	3,488,838	4,408,838	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	943,948	943,948	16
17	Accumulated Depreciation (book methods)	(1,104,287)	(1,400,731)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,332,502	\$ 3,981,058	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,806,183	\$ 5,520,307	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 483,023	\$ 483,023	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	176,559	176,559	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	316,150	316,150	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Liab</u>	(1)	(1)	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 975,731	\$ 975,731	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>Due to Related Party</u>	2,092,793	3,619,439	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,092,793	\$ 3,619,439	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,068,524	\$ 4,595,170	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,737,659	\$ 925,137	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,806,183	\$ 5,520,307	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,042,655	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,042,655	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,443,120)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Corp Office period 13 Adj 2000	(567,757)	15
16	Other (describe) Corp Office period 13 Adj 2001	2,705,881	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (4,304,996)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,737,659	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,045,604	1
2	Discounts and Allowances for all Levels	(1,216,147)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,829,457	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	673,327	6
7	Oxygen	6,954	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 680,281	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14,117	13
14	Non-Patient Meals	4,926	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	169,457	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	67,483	19
20	Radiology and X-Ray	76,353	20
21	Other Medical Services	400,236	21
22	Laundry	8,115	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 740,687	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	56	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 56	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	(9,642)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (9,642)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,240,839	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	883,104	31
32	Health Care	2,685,100	32
33	General Administration	2,818,536	33
	B. Capital Expense		
34	Ownership	341,150	34
	C. Ancillary Expense		
35	Special Cost Centers	4,903,347	35
36	Provider Participation Fee	52,722	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,683,959	40
41	Income before Income Taxes (line 30 minus line 40)**	(6,443,120)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (6,443,120)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Ridgeland Center# 0037937Report Period Beginning: 01/01/01Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,974	2,124	\$ 56,159	\$ 26.44	1
2	Assistant Director of Nursing	1,947	2,081	49,527	23.80	2
3	Registered Nurses	11,521	12,242	294,906	24.09	3
4	Licensed Practical Nurses	17,332	18,760	365,353	19.48	4
5	Nurse Aides & Orderlies	58,924	63,859	700,648	10.97	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,456	7,183	80,532	11.21	10
11	Social Service Workers	4,409	4,923	85,691	17.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,692	20,833	234,025	11.23	15
16	Dishwashers					16
17	Maintenance Workers	3,573	3,969	63,440	15.98	17
18	Housekeepers	13,729	15,047	120,097	7.98	18
19	Laundry	1,683	1,882	13,733	7.30	19
20	Administrator	2,091	2,287	72,478	31.69	20
21	Assistant Administrator					21
22	Other Administrative	11,652	12,482	159,077	12.74	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,791	4,276	48,422	11.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,774	171,948	\$ 2,344,088 *	\$ 13.63	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Mthly	9,537	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	per bed chrg	5,000	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 14,537		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,314	\$ 159,210	10, 3	50
51	Licensed Practical Nurses	4,210	144,364	10, 3	51
52	Nurse Aides	5,910	119,747	10, 3	52
53	TOTAL (lines 50 - 52)	13,434	\$ 423,321		53

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Ridgeland Center

STATE OF ILLINOIS

0037937

Report Period Beginning:

01/01/01

Ending:

Page 23

12/31/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL Hlth Care Assoc \$4805
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 59,437 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 52,722
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? YES Indicate the amount. \$ 1,312
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: KPMG Peat Marwick The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. NOT YET AVAILABLE
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

RIDGELAND CENTER

MEDICAID #: 22-3152450001

COST REPORT PERIOD: JAN 1, 2001 - DEC 31, 2001

SPECIAL COST CENTERS

PAGE 4 - LINE 43

	<u>REFER.</u>	<u>COST</u>
Business Privilege Tax	V4.4303	3,918
X-Ray Expense	V4.4303	6,217
Laboratory Fees	V4.4303	15,926
X-Ray Expense	V4.4303	<u>46,278</u>
 TOTAL		 <u><u>72,338</u></u>

RIDGELAND CENTER
MEDICAID #: 22-3152450001
COST REPORT PERIOD: JAN 1, 2001 - DEC 31, 2001
MISCELLANEOUS REVENUE
PAGE 19 - LINE 28

<u>Summary</u>	<u>Amount</u>
Prior period patient revenue	9,837
Cash receipt (employee/wipes)	(28)
Copy revenue	(40)
Resident eye exam	(95)
Garnishment revenue	<u>(32)</u>
 TOTAL	 <u><u>9,642</u></u>